

**DEPARTMENT OF HEALTH AND FAMILY SERVICES**Division of Health Care Financing  
HCF 10100 (Formerly DES 12277) (01/03)**STATE OF WISCONSIN**

WI Statutes s.49.47

**WISCONSIN MEDICAID/BADGERCARE FAMILY APPLICATION****Before completing this form, read the attached instructions. Use black or blue ink only.****SECTION I – CLIENT INFORMATION**

Do you need help paying for health care for any of the previous three months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is in your household anyone blind, disabled or incapacitated? <input type="checkbox"/> Yes <input type="checkbox"/> No	Check the language in which you want the notices printed. <input type="checkbox"/> English <input type="checkbox"/> Spanish	Language spoken in the home.	Case Number	Date Received
Name of Person Applying for Aid (Last, First, MI)			Telephone Number (include area code)	We assume your children attend school full time. List names of minor children <u>not</u> attending school full time.	
Address (Street, City, State, Zip Code)			Mailing Address (only if different from residence) (Street, City, State, Zip Code)		

**SECTION II – GENERAL INFORMATION (Refer to instructions to complete this section.)**

Names of all family members living in your household. (Example: Yourself, your spouse, father, mother, children, stepchildren, etc.) Please add second sheet of paper if more room is needed.	Applying for Medicaid or BadgerCare?	Applying for Family Planning Waiver?	Social Security Number (Applicants Only)	Date of Birth (MM/DD/YY)	Gender	Marital Status Code	U.S. Citizen (Applicants Only)	Race or Ethnic Code (Optional)	Relationship to Applicant
Name (Last, First, MI)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			M F		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			M F		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			M F		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			M F		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			M F		<input type="checkbox"/> Yes <input type="checkbox"/> No		

**SECTION III – ABSENT PARENT INFORMATION (Refer to instructions to complete this section.)**

Do any children have a natural or adoptive mother or father who is not living at home? <input type="checkbox"/> Yes <input type="checkbox"/> No (Add a second sheet if more room is needed.)					
Name of Parent (Last, First, MI)	Social Security Number	Date of Birth	Name(s) of Child(ren)	Relationship to Child	
				<input type="checkbox"/> Mother <input type="checkbox"/> Father	
				<input type="checkbox"/> Mother <input type="checkbox"/> Father	
Reason for Parent's Absence	Date Parent Left Household	Date Last Contact With Parent	Case Number	Court Order of Divorce / Paternity County	State

**SECTION IV – EMPLOYMENT**

Are you or any household members working? <input type="checkbox"/> Yes <input type="checkbox"/> No (If you answered "Yes" complete below.)		Is anyone listed below a migrant worker? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name Working Person	Employer (Name, Address and Telephone)	Date Employment Began	Gross Monthly Earnings Expected This Month (Before Taxes and Deductions)	Gross Monthly Earnings Expected Next Month (Before Taxes and Deductions)

**SECTION V – SELF-EMPLOYMENT**

Are you or any household members self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Name (Last, First, MI)	Business (Name and Address)	Type of Business	Net Annual Income	Depreciation Amount Claimed	Income you Expect to Earn this Year

**SECTION VI - UNEARNED INCOME (Refer to instructions to complete this section.)**

Does anyone in your household receive unearned income? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered "Yes" complete section below for each income type. (Add a second sheet of paper if more room is needed.)							
Type of Income	Yes/ No	Name	Gross Monthly Amount	Type of Income	Yes/No	Name	Gross Monthly Amount
Social Security / Supplemental Security Income (SSI)	<input type="checkbox"/> <input type="checkbox"/>		\$	Disability / Sick Pay	<input type="checkbox"/> <input type="checkbox"/>		
Maintenance / Child Support	<input type="checkbox"/> <input type="checkbox"/>		\$	Interest / Dividends	<input type="checkbox"/> <input type="checkbox"/>		\$
Workers / Unemployment Compensation	<input type="checkbox"/> <input type="checkbox"/>		\$	Veterans Benefits	<input type="checkbox"/> <input type="checkbox"/>		\$
Other income (describe)	<input type="checkbox"/> <input type="checkbox"/>		\$	Other income (describe)	<input type="checkbox"/> <input type="checkbox"/>		\$

**SECTION VII – Insurance**

Does any person have medical / health insurance coverage now, or in the previous three months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name / Address of Insurance Co	Policyholder Name	Policy Number	Date Began	Date Ended	Who is covered under the policy?

**SECTION VIII – Child Care** (Add a second sheet of paper if more room is needed.)

Does anyone pay for child or adult care so they can work, look for work, go to school or receive training?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who pays for the care?	Who do you pay?	Does s/he live in your household? <input type="checkbox"/> Yes <input type="checkbox"/> No	Who is the care for?	Monthly Amount \$

**SECTION IX - Child Support** (Add a second sheet of paper if more room is needed.)

Does anyone pay child support?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who pays the child support?	Who receives the child support payments?	Monthly Amount \$

**SECTION X – Pregnancy** (Add a second sheet of paper if more room is needed.)

Is any member of your household pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of pregnant woman?	Due Date	Are multiple births expected? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of babies expected?

**SECTION XI – RIGHTS AND RESPONSIBILITIES**

Please read the Rights and Responsibilities section on the instructions before signing.

I understand the questions and statements on this application form. I understand the penalties for giving false information or breaking the rules. I certify, under penalty of false swearing, that all my answers are correct and complete to the best of my knowledge, including information provided about the citizenship status of each household member applying for benefits. I understand and agree to provide documents to prove what I have said. I understand that the agency may contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits.

**SIGNATURE** - Applicant or Authorized Representative

Date Signed